

making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(d) *Actions following denial.* If an MA organization denies a request for expedited determination, it must take the following actions:

(1) Automatically transfer a request to the standard timeframe and make the determination within the 14-day timeframe established in § 422.568 for a standard determination. The 14-day period begins with the day the MA organization receives the request for expedited determination.

(2) Give the enrollee prompt oral notice of the denial and subsequently deliver, within 3 calendar days, a written letter that—

(i) Explains that the MA organization will process the request using the 14-day timeframe for standard determinations;

(ii) Informs the enrollee of the right to file an expedited grievance if he or she disagrees with the MA organization's decision not to expedite; and

(iii) Informs the enrollee of the right to resubmit a request for an expedited determination with any physician's support; and

(iv) Provides instructions about the grievance process and its timeframes.

(e) *Action on accepted request for expedited determination.* If an MA organization grants a request for expedited determination, it must make the determination and give notice in accordance with § 422.572.

(f) *Prohibition of punitive action.* An MA organization may not take or threaten to take any punitive action against a physician acting on behalf or in support of an enrollee in requesting an expedited determination.

[63 FR 35107, June 26, 1998, as amended at 65 FR 40329, June 29, 2000; 70 FR 4739, Jan. 28, 2005]

§ 422.572 Timeframes and notice requirements for expedited organization determinations.

(a) *Timeframe.* Except as provided in paragraph (b) of this section, an MA organization that approves a request for expedited determination must make its determination and notify the enrollee (and the physician involved, as appro-

priate) of its decision, whether adverse or favorable, as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.

(b) *Extensions.* The MA organization may extend the 72-hour deadline by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an MA organization's decision to deny). When the MA organization extends the deadline, it must notify the enrollee in writing of the reasons for the delay and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the MA organization's decision to grant an extension. The MA organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

(c) *Confirmation of oral notice.* If the MA organization first notifies an enrollee of an adverse expedited determination orally, it must mail written confirmation to the enrollee within 3 calendar days of the oral notification.

(d) *How the MA organization must request information from noncontract providers.* If the MA organization must receive medical information from noncontract providers, the MA organization must request the necessary information from the noncontract provider within 24 hours of the initial request for an expedited organization determination. Noncontract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the MA organization in meeting the required timeframe. Regardless of whether the MA organization must request information from noncontract providers, the MA organization is responsible for meeting the timeframe and notice requirements of this section.

(e) *Content of the notice of expedited determination.* (1) The notice of any expedited determination must state the specific reasons for the determination in understandable language.

(2) If the determination is not completely favorable to the enrollee, the notice must—

(i) Inform the enrollee of his or her right to a reconsideration;

(ii) Describe both the standard and expedited reconsideration processes, including the enrollee's right to request, and conditions for obtaining, an expedited reconsideration, and the rest of the appeal process; and

(iii) Comply with any other requirements specified by CMS.

(f) *Effect of failure to provide a timely notice.* If the MA organization fails to provide the enrollee with timely notice of an expedited organization determination as specified in this section, this failure itself constitutes an adverse organization determination and may be appealed.

[63 FR 35107, June 26, 1998, as amended at 65 FR 40329, June 29, 2000; 70 FR 4739, Jan. 28, 2005]

§ 422.574 Parties to the organization determination.

The parties to the organization determination are—

(a) The enrollee (including his or her representative);

(b) An assignee of the enrollee (that is, a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);

(c) The legal representative of a deceased enrollee's estate; or

(d) Any other provider or entity (other than the MA organization) determined to have an appealable interest in the proceeding.

[63 FR 35107, June 26, 1998, as amended at 75 FR 19812, Apr. 15, 2010]

§ 422.576 Effect of an organization determination.

The organization determination is binding on all parties unless it is reconsidered under §§ 422.578 through 422.596 or is reopened and revised under § 422.616.

§ 422.578 Right to a reconsideration.

Any party to an organization determination (including one that has been reopened and revised as described in § 422.616) may request that the deter-

mination be reconsidered under the procedures described in § 422.582, which address requests for a standard reconsideration. A physician who is providing treatment to an enrollee may, upon providing notice to the enrollee, request a standard reconsideration of a pre-service request for reconsideration on the enrollee's behalf as described in § 422.582. An enrollee or physician (acting on behalf of an enrollee) may request an expedited reconsideration as described in § 422.584.

[74 FR 1542, Jan. 12, 2009]

§ 422.580 Reconsideration defined.

A reconsideration consists of a review of an adverse organization determination, the evidence and findings upon which it was based, and any other evidence the parties submit or the MA organization or CMS obtains.

§ 422.582 Request for a standard reconsideration.

(a) *Method and place for filing a request.* A party to an organization determination or, upon providing notice to the enrollee, a physician who is treating an enrollee and acting on the enrollee's behalf, must ask for a reconsideration of the determination by making a written request to the MA organization that made the organization determination. The MA organization may adopt a policy for accepting oral requests.

(b) *Timeframe for filing a request.* Except as provided in paragraph (c) of this section, a request for reconsideration must be filed within 60 calendar days from the date of the notice of the organization determination.

(c) *Extending the time for filing a request.* (1) *General rule.* If a party or physician acting on behalf of an enrollee shows good cause, the MA organization may extend the timeframe for filing a request for reconsideration.

(2) *How to request an extension of timeframe.* If the 60-day period in which to file a request for reconsideration has expired, a party to the organization determination or a physician acting on behalf of an enrollee may file a request for reconsideration with the MA organization. The request for reconsideration and to extend the timeframe must—